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ABSTRACT

Anxiety management training (AMT), developed by Suinn and Richardson, is a short-term treatment procedure for alleviating a variety of manifestations of anxiety. It is based on the theory that anxiety or fear responses themselves can become discriminative stimuli and that clients can be conditioned to respond to these stimuli with antagonistic responses of relaxation and feelings of competence which remove the anxiety through reciprocal inhibition. This study investigated the efficacy of three variations of AMT--physiological cues only, physiological cues plus scenes, and scenes only. Subjects were college students who were seeking help for "free-floating" anxiety problems. Questionnaire data were obtained on the Manifest Anxiety Scale (MAS) and the Anxiety Symptom Check List (ASCL). Post-treatment interview data were also obtained. Data were analyzed by separate analysis of variance designs. In addition to comparing AMT groups to each other, data from a waiting list control group and a no-problem, no-treatment control group were obtained and compared to the treatment group data. The results indicated that all three variations of AMT were effective in alleviating "free-floating" anxiety. (Author)

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THE USE OF THREE VARIATIONS OF ANXIETY MANAGEMENT TRAINING IN THE TREATMENT OF GENERALIZED ANXIETY[1]

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ABSTRACT

Anxiety Management Training (AMT), developed by Suinn and Richardson, is a short-term treatment procedure for alleviating a variety of manifestations of anxiety. It is based on the theory that anxiety or fear responses themselves can become discriminative stimuli and that clients can be conditioned to respond to these stimuli with antagonistic responses of relaxation and feelings of competence which remove the anxiety through reciprocal inhibition. Anxiety management training involves the steps of: 1) training in deep muscle relaxation; 2) training in visualizing a pleasant scene, an anxiety scene, and a success scene of each client's own choosing or focusing on the physiological cues associated with each of the situations if scenes are not used; and 3) learning to inhibit feelings of anxiety through the use of a control cue and by switching to feelings of relaxation and feelings of competence. This procedure differs from systematic desensitization in that no hierarchies are necessary and once the technique is learned, clients can use it for coping with future sources of anxiety without the necessity of returning to therapy.

This study investigated the efficacy of three variations of AMT: 1) AMT I, physiological cues only; 2) AMT II, physiological cues plus scenes; and 3) AMT III, scenes only.

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designs. The three AMT groups were compared to the waiting list control group and the no-problem, no-treatment control group at pretesting and again following treatment. Means, standard deviations, and differences between means for all groups are summarized in Table 1.

Prior to receiving treatment the AMT groups were not significantly different from the waiting list control group on the MAS and ASCL (MAS: AMT I, F = .0398; AMT II, F = .0110; AMT III, F = .0514; ASCL: AMT I, F = .2306; AMT II, F = 1.4118; AMT III, F = .4584). Also at pretesting the AMT groups were significantly higher than the no-problem, no-treatment control group on the MAS and ASCL (MAS: AMT I, F = 25.1679; AMT II, F = 12.8184; AMT III, F = 10.7519; ASCL: AMT I, F = 24.2265; AMT II, F = 22.1438; AMT III, F = 19.6115). The F values were significant at the .001 level except for the MAS for AMT III which was significant at the .01 level.

Following treatment the three AMT groups were not significantly different from the non-anxious no-problem, no-treatment control group on the MAS (AMT I: F = 2.4454; AMT II: F = 1.5444; AMT III: F = 2.8959). The post treatment results on the ASCL were unexpected. Even though the mean scores decreased a great deal, the three AMT groups were still significantly higher than the no-problem, no-treatment control group (AMT I: F = 10.8305, $p < .01$; AMT II: F = 4.7392, $p < .05$; AMT III: F = 5.2245, $p < .05$). Further analysis of the subscale scores revealed that only the AMT II treatment procedure resulted in any significant reductions on the ASCL. The Frequency and Intensity subscales decreased significantly ($p < .05$) while the Interference subscale approached but did not reach significance at the .05 level.

The three AMT groups were compared to each other at pretesting and again at posttesting on the MAS and ASCL. There were no significant differences between the groups indicating that the effects of the three variations of AMT were similar on the MAS and ASCL total scores.

Discussion

The data offer support for the effectiveness of all three variations of AMT on reducing "free-floating" anxiety, as measured by the MAS, to a level similar to that reported by non-anxious Ss. The substantial but non-significant reductions in ASCL total scores bear further scrutiny. By examining the ASCL subscales it becomes clear that only AMT II, the combination of physiological cues and scenes, resulted in statistically significant reductions in anxiety on two of the three subscales, Frequency and Intensity. However, the same two subscales approached statistical significance in the AMT I and II treatment groups. It seems likely that these results mean that AMT has some substantial effect in reducing the number of times clients experience anxiety and the intensity of it when it does occur; but that when anxiety occurs it before treatment. The reasons why AMT II is more effective in reducing *S*s' physical manifestations of anxiety are not directly explicable but the results do suggest that AMT II may be the best of the three procedures. The AMT II procedure also has the advantage of using physiological cues to inhibit anxiety for those clients who cannot visualize clearly and, conversely, uses visual imagery to inhibit anxiety for those clients who tend to deny or be unaware of physical manifestations of anxiety.

Some very limited follow-up data on 13 *S*s in this study were obtained. The follow-up consisted of a brief 10 to 15 minute interview conducted at a median of two weeks following the completion of treatment. Subjects were asked to respond to how things had gone after treatment and were encouraged to give behavioral report data. Two *S*s stated that they did not feel any different and four *S*s said that they no longer felt anxious but attributed that to not being in any anxiety provoking situations. The remaining seven *S*s felt that they could use the anxiety control in many situations and that it was becoming more effective the more it was used. Four *S*s mentioned that they felt more socially secure and attributed the feeling to the loss of their previous fear that they might lose control of their anxiety at any moment. To these *S*s the experience of control over a previously uncontrollable response was an extremely rewarding event. By the termination sessions some Ss were less inhibited about expressing feelings and revealing more of a personal nature about themselves. It seems plausible that the use of AMT to reduce anxiety may prove to be a useful adjunct to insight-oriented therapy and could lead to relevant expression and self-understanding more quickly than the current approach of allowing the client to progress slowly on the work of therapy.

Cautions should be taken in the application of AMT until further research is completed. The use of a technique of deliberately inducing high levels of anxiety in clients in order to teach the control cue and to countercondition the anxiety is a risky procedure. A limited number of Ss in this present study actually experienced fairly severe anxiety attacks during anxiety induction. However, these same clients were able to control their anxiety and switch back to relaxation without further difficulty. Nevertheless, therapists should be well trained in the use of the AMT technique and be able to judge when to terminate the anxiety induction without pushing clients too hard.

Even though the AMT technique appears to hold promise for the treatment of "free-floating" anxiety, additional research is needed and more extensive follow-up data should be obtained. An area of theoretical research might include studies designed to determine whether the effects of treatment are attributable to counterconditioning, experimental extinction, reactive inhibition, aspects of instrumental conditioning or other principles of learning. If the studies in this area by Davidson (1968), Lomont (1962), and [illegible], [illegible], and Richardson (1971) can be taken as indications of the interest in theoretical learning issues, AMT offers a good testing ground to resolve some of the theoretical issues. It seems likely that AMT may be a complex process made up of a number of learning principles being applied at the same time. The process of asking Ss to experience high levels of anxiety and to switch it off only when the therapist requests may involve following the response as well as experimental extinction. The pairing of physiological cues for anxiety with anxiety reduction involves counterconditioning. Finally, the use of the anxiety control cue in extra-therapy situations may involve instrumental conditioning as well as counterconditioning.

FOOTNOTES

[1] The data presented in this paper are a part of the author's doctoral dissertation submitted to the Psychology Department, Colorado State University, Fort Collins, Colorado 80521.

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